Dr. Kimberly A. Lemke, P.C.
1805 N. Mill Street, Suite B
Naperville, IL 60563

AUTHORIZATION TO RELEASE INFORMATION

Patient: _____

D.O.B. _____/____/_____

I/We authorize and request Dr. Kimberly A. Lemke, P.C., to release confidential professional information including personal, psychiatric, medical, laboratory, psychological testing data and interpretation, social, educational, substance abuse, clinical information, opinions, and/or any other information regarding his/her contacts with myself to:

NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE: _____ **FAX:** _____

I/We also authorize and request the same above named person(s) to release any and/or said information to Dr. Kimberly A. Lemke, P.C.

I understand that my refusal to consent to release the information specified above will prevent disclosure of such materials to the person/facilities named herein, with the potential consequence of reduced accuracy and completeness of my care.

The release is valid through _____/____/_____ unless dated as follows _____/____/_____

_____ _____

Patient Signature (if age 12 or older) Date

_____ _____

Parent/Guardian Signature Signature of Witness

**If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.